STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. BUILDING _____ B. WING _____	C 04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE OF POQUOSON HEALTH AND REHAB	1 VANTAGE DRIVE POQUOSON, VA 23662

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/11/17 through 04/13/17. Two complaints were investigated. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 47 at the time of the survey. The survey sample consisted of 17 residents, 13 current Resident reviews (Resident #1 through Resident #12 and Resident #17) and 4 closed record reviews (Resident #13 through Residents #16).	F 000		
F 155 SS=D	RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES CFR(s): 483.10(c)(6)(8)(g)(12), 483.24(a)(3) 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 155		5/4/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/05/2017

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F 155	Continued From page 1 medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, clinical record review, observations, staff and family interview and facility documentation, the facility	F 155	DON/ADON will reeducate licensed nurses regarding consents for flu and/or any other vaccines; when residents/family	

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F 155	Continued From page 2 staff failed to honor the rights of 1 out of 17 residents (Resident #7) in the survey sample. Resident #7's Resident Representative (RR), upon admission to the nursing facility, signed a refusal form for the influenza vaccine. The nursing staff did not honor the resident's request, but administered the vaccine. The finding include: Resident #7 was admitted to the nursing facility on 1/28/15 with diagnoses that included dementia, high blood pressure, depression and hearing impairment. The most recent Minimum Data Set (MDS) assessment was an annual dated 3/17/17 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 7 out of a possible score of 15 which indicated the resident was severely impaired in the skills needed for daily decision making. The MDS coded the resident to have received the influenza vaccine during the flu season 10/6/16. The care plan dated 10/6/16 identified a medication error, resident was given the annual Flu vaccine without approval from resident on the evening of 10/6/16. The goal set for the resident by the staff was that the resident would have no adverse effects from the flu vaccine. The approach the staff would take to prevent further medication errors was that nursing would verify consent prior to administering the flu vaccine. The facility's "Resident Immunization Consent or Refusal Form" indicated the Resident's Representative had received the information	F 155	refuse vaccines the resident is not to receive the vaccine. DON/ADON will reeducate the staff regarding resident right to refuse; all residents have the right refuse and staff must honor resident/responsible party choice. Immunizations/vaccines to be verified by licensed nurses upon admission, quarterly and annually to ensure all consents are documented properly; consent will be verified prior to administration of vaccinations. DON/ADON will audit resident charts on a monthly basis to ensure that residents have signed consents or refusals for vaccinations. Resident #7 will be required to complete consent form in 2017 and nursing staff will proceed accordingly. Date of completion 5/4/2017	

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F 155	Continued From page 3	F 155		

regarding the risks and benefits of the Influenza and chose to "Refuse" the vaccine. The RR wrote "NO, NO" and underlined the word "NO". The document was signed on 9/15/16. The same form was signed the previous year 10/29/15 with refusal of the influenza vaccine and the resident did not receive the vaccine.

The resident was observed 4/12/17 at 1:00 p.m. in her wheelchair in the hallway near the nurse's station. She was not able to be interviewed with any certainty about having received the influenza vaccine due to her cognitive status.

During an interview with Licensed Practical Nurse (LPN) #1 on 4/12/17 at 1:30 p.m., she stated, "I remembered the nurse (no longer employed by the facility) who said she gave the vaccine when the Consent Form indicated the family did not want the resident to have it. She was very upset, but was thankful nothing happened to the resident."

A telephone conversation with the complainant was conducted on 4/13/17 at 5:11 p.m. She stated the resident had bad experiences in the past when administered the influenza vaccine, thus the family decided she not receive it, and signed the document that indicated their wishes be honored for the resident.

The above information was shared with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 4/13/17 at 5:20 p.m. The Administrator presented a document created 12/12/16 that added the Influenza vaccine as an allergy.

The policy and procedures titled "Influenza

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F 155	Continued From page 4 Vaccine-Resident Health Program" dated 2/2017 indicated that the informed consent be obtained from the resident or the resident's responsible arty if indicated; have the resident/responsible party sign the consent, indicating the desire to receive the vaccine, or the wish to decline.	F 155		
F 167 SS=C	COMPLAINT DEFICIENCY RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(10)(i)(11) (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying	F 167		4/18/17

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F 167	Continued From page 5 information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to make the 3 preceding years of survey results readily accessible to residents and visitors. The findings included: During an observation conducted on 4/11/17 at 7:30 pm, a copy of the facility survey results in a white binder labeled "Survey Results" in the lobby was reviewed. The binder was located in a wall file organizer near the entrance to the unit. The binder contained a copy of the facility survey result completed on 3/3/16. There were no facility survey results for the 3 preceding years easily accessible for residents and families. There was a notice in a 7 x 9 frame displayed on a table upon entry into the main lobby but it only stated that the survey results are located in the main lobby. There were no specific instructions for residents and families on how to access or who to contact to gain access to the survey results for the 3 preceding years. On 4/12/17 at 1:15 pm, the Administrator was interviewed in his office and was requested to provide copies of the survey results during the 3 preceding years. He pulled the 2014, 2015 and 2016 survey results from his desk file drawer in his office where they are usually kept. He was asked if these survey results would have been available upon request on 4/11/17 at 7:30 pm, he stated, "No, the staff would not have access to this office." A copy of the facility policy that addressed posting	F 167	Survey results for 3 preceding years were placed in "survey results" binder on 4/12/2017 and are easily accessible to residents and visitors in the main lobby. The notice of surevy results availabilty was updated on 4/18/2017 to inform resident and visitors that surevy results for 3 preceding years are available for review in the "survey results" binder located across from reception area in the main lobby. Date of completion 4/18/2017.	

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F 167	Continued From page 6 and accessibility of the survey results was requested and the facility did not have a policy On 4/13/17 at approximately 5:00 pm, the above findings were shared with the Administrator, Director of Nursing Services and Assistant Director of Nursing Services. No additional information was provided.	F 167		
F 226 SS=E	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse,	F 226		5/4/17

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F 226	Continued From page 7 neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on the facility document review and staff interview, the facility staff a. Failed to obtain a Sworn Disclosure Statement from 5 out of 5 employees that were reviewed as part of the abuse screening requirement. b. Failed to implement the 7 components of the abuse policy to include the abuse training for 2 out of 5 employees that were reviewed. The findings included: On 4/13/17 at approximately 3:30 pm, an Abuse Prohibition Review was conducted and reviewed the facility documents and abuse policy provided by the facility. Review of 5 employee records documented there were no signed copies of the Sworn Disclosure Statement for 5 employees (1 RN, 1 LPN, 2 CNAs, and 1 Administrator). Review of training records provided by the facility titled "Abuse, Types of Abuse, Reporting Abuse, Mandatory Reporting Within 2 hours" dated 4/5/17 at 1:15 pm, presented by the Assistant Director of Nursing Services, there were 2 out 5 employees who did not receive Abuse Training (1 LPN, 1 CNA). There were no other records on abuse training presented by the facility. The facility Policies and Procedures for Resident Abuse dated 02/17, read, in part, as follows: "...II.	F 226	New hires will complete sworn disclosure statement upon hire date; current staff will complete sworn disclosure statement by 5/1/2017, and copy will be placed in employee file. DON/ADON will provide abuse education/training to staff upon intial hire and annually. ED/BOM will complete monthly audits of employee files to check for sworn disclosure statement and abuse education. Current staff will be reeducated on abuse by 5/1/2017. Date of completion 5/4/2017.	

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F 226	Continued From page 8 Screening - Persons applying for employment with Facility will be screened for a history of abuse, neglect, or mistreating residents to include: a. References from previous or current employers (with applicant permission) b. Criminal background check. c. Abuse check with appropriate licensing board and registries, prior to hire. d. Sworn Disclosure Statement prior to hire. e. Verify license or registration prior to hire. III. Training - Employees will receive education and training on Resident Rights, Resident Abuse, and Abuse Reporting during orientation and annually thereafter. Additional education and training will be provided as deemed necessary." On 4/13/17 at 4:30 pm, the Administrator was interviewed and was asked what his expectation was in regards to abuse screening and training and he stated his expectation was that the sworn disclosure statement and abuse training will be done. On 4/13/17, at approximately 5:30 pm, the above findings were shared with the Administrator, Director of Nursing Services and Assistant Nursing Services. No additional information was provided.	F 226		
F 274 SS=D	COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE CFR(s): 483.20(b)(2)(ii) (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For	F 274		5/4/17

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F 274	Continued From page 9 purpose of this section, a “significant change” means a major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident’s health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review, and review of the facility's policy the facility staff failed to complete a significant change assessment for 1 of 17 residents (Resident #2), in the survey sample. Facility staff failed to complete a significant change Minimum Data Set (MDS) assessment for Resident #2 after staff recognized the resident had experienced major declines in 2 or more areas. The findings included: Resident #2 was originally admitted to the facility 12/21/16 and had never been discharged from the facility. The current diagnoses included; Traumatic brain injury, dementia, hearing loss, hypertension, reflux disease, arthritis and cardiac dysrhythmias. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/30/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This	F 274	MDS Coordinator held a meeting with the IDT on 4/19/2017. A review of residents, skilled and non-skilled, was conducted. Upon completion of the review, it was determined that the IDT team would meet on the third Monday of each month to regularly review residents for significant changes. Information will be kept by the MDS Coordinator for review. The IDT will discuss at morning meeting any changes in resident status that could result in a need for a Significant Change MDS. A Significant Change MDS was opened 4/13/2017 on Resident #2 It was completed, submitted and accepted. MDS Coordinator will compare the prior MDS when completing the current MDS to determine if a Significant Change is needed. Date of completion 5/4/2017.	

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indicated Resident #2's cognitive abilities for daily decision making was severely impaired. Resident #2 was also coded for having no behavior or mood problems.

The 3/30/17 quarterly MDS assessment revealed in section "B" Hearing, Speech and Vision; Resident #2 was coded as wearing hearing aids and missing some part/intent of the message but able to comprehend most messages and having difficulty communicating some words or finishing thoughts. In section "G" Physical Functioning the assessment was coded that Resident #2 required extensive assistance of two for transfers, extensive assistance of one for bed mobility. In section "H" Bladder and Bowels the resident was coded as totally incontinent of bowels and bladder. The 3/30/17 MDS further coded the resident with a significant non-physician prescribed weight loss and weighing 160 pounds. In section "M" Skin Conditions, Resident #2 was coded as having two stage two pressure ulcers, the oldest acquired 2/8/17.

The comprehensive MDS assessment with an ARD of 12/28/16, in section "B" Hearing, Speech and Vision; coded the resident with no communication deficits while wearing a hearing aid. Section "G" Physical Functioning revealed the resident required limited assistance of one person with bed mobility and transfers, and section "H" Bladder and Bowels the resident was coded as having total control of bowels and utilized an indwelling catheter for urinary elimination. The 12/28/16 MDS assessment also coded the resident as weighing 204 pounds. In section "M" Skin Conditions, Resident #2 was

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F 274	Continued From page 11 coded as having no pressure ulcers. An interview was conducted with the MDS Coordinator on 4/13/17 at approximately 3:40 p.m. The MDS Coordinator stated she did not compare the MDS assessments at the time the quarterly assessment was completed therefore; the significant change MDS assessment was not completed. The MDS Coordinator further stated the team talked about residents changes daily and updated the person-centered plan of care accordingly. The MDS Coordinator stated a significant change MDS assessment would be opened today for the team to complete. The above findings were shared with the Administrator, Director of Nursing and Assistant Director of Nursing on 4/13/17 at approximately 5:40 p.m. The Assistant Director of Nursing stated the facility had no policy on completion of MDS assessments but follow the (MDS) 3.0 Resident Assessment Instrument (RAI) manual. A "significant change" is a decline or improvement in a resident's status that: 4. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting" (for declines only); 5. Impacts more than one area of the resident's health status; and 6. Requires interdisciplinary review and/or revision of the care plan (MDS 3.0 RAI users manual, Chapter 2 page 2-22, October 2016).	F 274		
F 313	TREATMENT/DEVICES TO MAINTAIN	F 313		5/4/17

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F 313 SS=D	Continued From page 12 HEARING/VISION CFR(s): 483.25(a)(1)(2) (a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- (1) In making appointments, and (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, clinical record review, the facility staff failed to ensure a resident with assistive devices was assisted to utilize the devices for 1 of 17 residents (Resident #2), in the survey sample. The facility staff failed to ensure Resident #2's assistive devices to maintain hearing were applied on a regular basis. The findings included: Resident #2 was originally admitted to the facility 12/21/16 and had never been discharged from the facility. The current diagnoses included dementia and hearing loss. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date	F 313	DON/ADON will conduct monthly audits of residents who have hearing devices to ensure devices are in place daily. DON/ADON will educate nursing staff on proper placement of hearing devices and ensure staff is following plan of care surrounding hearing devices. Resident #2 care plan was verified; nursing staff aware of plan of care regarding hearing devices. Date of completion 5/4/2017.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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(ARD) of 3/30/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were severely impaired. Resident #2 was also coded for having no behavior or mood problems, required extensive assistance of two for transfers, extensive assistance of one for bed mobility, personal hygiene, bathing, dressing and toilet use. The assessment coded the resident as totally incontinent of bowels and bladder.

In section "B" Hearing Speech and Vision of the 3/30/37 MDS assessment, Resident #2 was coded utilizing a hearing aid or other hearing appliance and usually understands what others say.

The interdisciplinary care plan currently in use dated 12/21/16, had a problem which read: "Impaired Communication due to Impaired cognition, impaired hearing - has bilateral hearing aids." The goal read: "Patient will be able to communicate basic needs through 7/5/17." The interventions included: "Ensure placement of hearing aids as needed. Speak at appropriate volume to facilitate patient hearing."

The current Physician order summary revealed a physician order dated 2/17/17 which read hearings aids to bilateral ears in the morning. Another physician order dated 2/16/17 read; remove hearing aids from bilateral ears and return to cart at bedtime. A physician order dated 3/23/17 read; change hearing aid batteries every Monday.

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Resident #2 was observed in the dining room at approximately 12:25 p.m. on 4/12/17. The resident was not wearing hearing aids and experienced difficulty understanding what was said to him and required the speaker to adjust tone and volume of their voice to enable hearing. Resident #2 was observed again on 4/12/17 at approximately 8:00 p.m., watching television and conversating with staff. The volume of the television could clearly be heard 2 rooms down and the staff yelled to enable the resident to hear what was said until the nurse finally turned the television's volume down. The resident was not wearing hearing aids.

An interview was conducted with Registered Nurse (RN) #1 about Resident #2's hearing aids on 4/12/17 at approximately 8:55 p.m. RN #1 stated the resident had hearing aids and they are applied each morning at approximately 6:00 a.m. and removed nightly at bedtime and placed in the medication cart. RN #1 stated "I need to check the orders and ensure the order is still current". The surveyor informed the nurse the resident didn't have the hearing aids in at lunch time on 4/12/17 and they were currently not in while staff was attempting to communicate with him and it resulted in staff yelling to communicate with the resident.

On 4/13/17 at approximately 12:35 p.m., Resident #2 was observed in the dining room having lunch. The surveyor asked the resident about the meals but the resident was unable to hear what was said to him. The hearings aids were not in either

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F 313	Continued From page 15 ear. Again, a change in speech volume and tone was required to communicate with the resident. An interview was conducted with RN #1 on 4/13/17 at approximately 1:15 p.m., RN #1 stated she was not aware the resident didn't have the hearing aids in but she would find out what was going on. RN #1 informed the surveyor at 1:30 p.m., the charge nurse for Resident #2 stated the resident refused application of the hearing aids that morning but the resident just accepted placement of the hearing aids. A nurses' note written 4/13/17 at 1:25 p.m.,stating such was observed in the electronic record by the surveyor. Resident #2 was observed in the hallway near the nurses' station at approximately 4:45 p.m., with bilateral hearing aids in place. The resident was able to communicate immediately with the surveyor using a soft voice. The above findings were shared with the Administrator, Director of Nursing and the Assistant Director of Nursing on 4/13/17 at approximately 5:20 p.m. The Assistant Director of Nursing stated the facility's expectation is for ordered and needed assistive devices to applied and utilized as directed.	F 313		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention	F 441		5/4/17

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and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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F 441	Continued From page 17 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure proper hand hygiene and use of gloves to prevent the spread of infection for 2 of 17 residents in the survey sample, Resident #17 and Resident #2. 1. Facility staff failed to ensure proper hand hygiene and use of gloves during a perineal care for Resident #17. 2. For Resident #2, the facility staff failed to ensure infection control measures were maintained during wound care and incontinence care.	F 441	DON/ADON will reeducate staff on infection control for the following: Biohazard/trash bags to not be placed on the floor when providing wound care with soiled dressings and/or wound products. Hand hygiene and proper hand hygiene techinique. Proper technique for incontinence care. DON/ADON will conduct monthly audits for proper technique for wound care; for	

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F 441	Continued From page 18 The findings included: 1. Resident #17 was admitted to the facility on 9/2/14. Diagnoses included but not limited to high blood pressure and Alzheimer's Disease. On the most recent Minimum Data Set (an assessment protocol) with an assessment reference date of 3/10/17, Residents #17 was coded as always incontinent for urinary and bowel. The Brief Interview for Mental Status (BIMS) was not conducted, Resident #17 has Alzheimer's Disease. On 4/12/17 at approximately 10:45 am, the surveyor observed CNA #2 perform perineal care on Resident #17. CNA #2 failed to wash hands prior to the procedure. CNA #2 put on a clean pair of gloves and proceeded to wash the resident's perineal area with soap and water. After cleaning the perineal area, CNA #2 did not remove the used soiled gloves. With soiled gloves on, CNA #2 proceeded to open the bedside drawer, touched several items in the drawer to look for the tube of perineal barrier cream and applied the barrier cream to the skin area between the thighs and lower abdomen. CNA #2 failed to change gloves, wash hands, and put on a new pair of clean gloves prior to applying the barrier cream on the resident's skin. On 4/13/17 at 9:30 am, RN #1 was interviewed and was asked to state the procedure on how CNAs should perform perineal care. She stated, "Wash hands, pull curtain, clean the perineal area, remove gloves, wash hands and put on clean gloves before applying cream."	F 441	proper technique for incontinence care provided; for proper technique for hand hygiene by staff. Date of completion 5/4/2017.	

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On 4/13/17 at 10:00 am, an interview was conducted with the Director of Nursing Services and she was asked what her expectations were when CNAs provide perineal care with application of a barrier cream. She stated, "dirty to clean", remove gloves after cleaning the perineal area, wash hands, put on clean gloves, then apply the barrier cream.

On 4/13/17 at 5:08 pm, the facility provided a copy of the "Perineal Care" procedure from a nursing textbook titled, "Nursing Procedures" 6th edition, page 563-564. The facility considered this as the facility policy and procedure for perineal care. It stated, "Perineal Care...Implementation - ...After cleaning the perineum*, apply ointment or cream as needed to prevent skin breakdown by providing a barrier cream between the skin and excretions*."

*Perineum -The area of the body between the anus and the vulva in females, and between the anus and the scrotum in males.
(Source: https://iffgd.org/medical-definitions-glossary-dictionary.html#P)

*Excretions - waste passed from the body (as urine or feces)
(https://www.merriam-webster.com/dictionary/excretion)

On 4/13/17 at approximately 5:30 pm, the above findings were shared with the Administrator, Director of Nursing Services, and Assistant Director of Nursing Services. No additional information was provided.

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2. Resident #2 was originally admitted to the facility 12/21/16 and had never been discharged from the facility. The current diagnoses included pressure ulcers of the left ischium, right ischium and right buttock.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/30/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were severely impaired. Resident #2 was also coded for having no behavior or mood problems, required extensive assistance of two for transfers, extensive assistance of one for bed mobility, personal hygiene, bathing, dressing and toilet use. The assessment coded the resident as totally incontinent of bowels and bladder.

During a wound care observation on 4/12/17 at approximately 8:05 p.m. through 8:45 p.m., Registered Nurse (RN) #1 was observed spreading a red biohazard bag on the floor at Resident #2 bedside to collect soiled bandages and soiled wound care products. All discharged wound care products and gloves were dropped into the red bag.

Resident #2 required incontinence care secondary to stool incontinence during wound care. A clear plastic was placed in the bed by RN #1 and all soiled products and the incontinence brief was put in the clear plastic bag. After incontinence care and prior to repositioning the resident RN #1 threw the clear plastic bag on the

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F 441	Continued From page 21 floor beside the red biohazard bag. An interview was conducted with Registered Nurse (RN) #1 on 4/12/17 at approximately 8:55 p.m. RN #1 stated she didn't know it was not okay to put trash or biohazard waste on the floor. The above findings were shared with the Administrator, Director of Nursing and the Assistant Director of Nursing on 4/13/17 at approximately 5:20 p.m. The Assistant Director of Nursing stated the facility didn't have a policy on disposal of trash. An unnamed and undated document was presented which stated the facility's expectation is for staff to dispose of all trash into proper bags and proper receptacles. Staff is not to place trash on the floor when providing care for residents. A policy titled "Biohazard Waste" dated 2/2017 read; Biohazard waste will be transferred and contained in such a way to prevent the transmission of infection disease.	F 441		